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SENATE BILL 460 By
McNally

HOUSE BILL 1439
By Shepard

AN ACT to amend Tennessee Code Annotated, Title 56, relative to recoupment of health care provider claims.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Title 56, Chapter 7, is amended by adding the following as a new part:

56-7-2901.

As used in this part:

(1) "Covered person" means a person on whose behalf an insurer offering a health benefit plan is obligated to pay benefits or provide services.

(2) "Health insurance coverage" has the same meaning as in § 56-7-109.

(3) "Health insurance entity" has the same meaning as in § 56-7-109.

(4) "Health care provider" means any person or entity performing services regulated pursuant to title 63 or title 68, chapter 11.

(5) "Retroactive denial of a previously paid claim" or "retroactive denial of payment" means any attempt by a health insurance entity retroactively to collect payments already made to a healthcare provider with respect to a claim by reducing other payments currently owed to the health care provider, by withholding or setting off

against future payments, by demanding payment back from a health care provider for a claim already paid or in any other manner reducing or affecting the future claim payments to the health care provider.

56-7-2902.

(a) A managed care entity shall not require a provider to appeal errors in payment where the health insurance entity has not paid the claim according to the contracted rate. Miscalculations in payments made by the health insurance entity shall be corrected and paid within thirty (30) calendar days upon the health insurance entity's receipt of documentation from the health care provider verifying the error.

(b) A health insurance entity shall not be required to correct a payment error to a provider if the provider's request for a payment correction is filed more than twelve (12) months after the date that the health care provider received payment for the claim from the health insurance entity.

56-7-2903.

(a) Except in cases of fraud committed by the health care provider, a health insurance entity may only retroactively deny reimbursements to a provider during the twelve-month period after the date that the health insurance entity paid the claim submitted by the health care providers.

(b) A health insurance entity that retroactively denies reimbursement to a health care provider under this section shall give the health care provider a written or electronic statement specifying the basis for the retroactive denial.

56-7-2904.

(a) If a health insurance entity determines that payment was made for services rendered to an individual who was not eligible for coverage, or that payment was made for services not provided by the covered person's health insurance coverage, the health insurance entity shall give written notice to the health care provider and:

(1) Request a refund from the health care provider; or

(2) Make a recoupment of the overpayment from the health care provider in accordance with § 56-7-2905.

(b) The provisions of (a) shall not apply if the health insurance entity made a representation of eligibility or coverage which was relied on in good faith by the health care provider and the services were performed by the health care provider.

56-7-2905. If a health insurance entity chooses to collect an overpayment made to a health care provider through a recoupment against future health care provider payments, the health insurance entity shall, within twelve (12) months from the date that the health insurance entity paid the claim, give the health care provider written documentation that specifies:

(1) The amount of the recoupment;

(2) The covered person's name to whom the recoupment applies;

(3) Patient identification number; and

(4) Date of service.

56-7-2906.

(1) If the commissioner of commerce and insurance finds a health insurance entity has failed to comply with the provisions of this part, the commissioner may impose a penalty of two (2) times the amount of the claim or five hundred dollars ($500) whichever amount is higher.

(2) If the alternative, the health care provider may seek injunctive or other appropriate relief in the chancery court of Davidson County.

56-7-2907. The commissioner shall adopt rules and regulations to ensure compliance with this part within one (1) year of the effective day of this act. All such rules shall be adopted in accordance with the provisions of title 4, chapter 5.

56-7-2908. The provisions of this part shall not be waived, voided or nullified by contract.

SECTION 2. If any provision of this act or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to that end the provisions of this act are declared to be severable.

SECTION 3. This act shall take effect July 1, 2003, the public welfare requiring it.